HAWAII ADMINISTRATIVE RULES

TITLE 16

DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

CHAPTER 12A

MEDICARE SUPPLEMENT POLICIES

SUBCHAPTER 1

GENERAL PROVISIONS

§16-12A-1 Objective. This chapter is intended to clarify and implement chapter 431:10A Part III, Hawaii Revised Statutes, and to assure the orderly implementation and conversion of medicare supplement insurance benefits and premiums due to changes in the federal medicare program; to provide for the reasonable standardization of the coverage, terms, and benefits of medicare supplement policies or subscriber contracts; to facilitate public understanding of such policies or subscriber contracts; to eliminate provisions contained in such policies or subscriber contracts which may be misleading or confusing in connection with the purchase of such policies or subscriber contracts; to eliminate

policy or subscriber contract provisions which may duplicate medicare benefits; to provide full disclosure of policy or subscriber contract benefits and benefit changes; and to provide for refunds of premiums associated with benefits duplicating medicare program benefits. [Eff 5/22/89] (Auth: HRS §§431:2-201, 431:10A-304) (Imp: HRS §§431:10A-104, 431:10A-105)

§16-12A-2 Authority. This chapter is issued pursuant to the authority vested in the commissioner of insurance under sections 431:2-201, 431:10A-303, and 431:13-203, HRS. [Eff 5/22/89] (Auth: HRS §§431:2- 201, 431:10A-303, 431:13-203) (Imp: HRS §431:10A-302)

§16-12A-3 Applicability and scope. (a) This chapter shall take precedence over other rules and requirements relating to medicare supplement policies or subscriber contracts only to the extent necessary to assure that benefits are not duplicated, that applicants receive adequate notice and disclosure of changes in medicare supplement policies and subscriber contracts, that appropriate premium adjustments are made in a timely manner, and that premiums are reasonable in relation to benefits.

(b) Except as provided, this chapter shall apply to all medicare supplement policies, subscriber contracts, and certificates delivered, or issued for delivery within this State or which are otherwise subject to the jurisdiction of this State on or after the effective date. [Eff 5/22/89] (Auth: HRS §§431:2-201, 431:10A-303) (Imp: HRS §§431:10A-301, 431:10A-302)

§16-12A-4 Definitions. Unless the context indicates otherwise, as used in this chapter:

"Applicant" means in the case of an individual medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and in the case of a group medicare policy or subscriber contract, the proposed certificate holder.

"Certificate" means any certificate issued under a group medicare supplement policy, which policy has been delivered or issued for delivery in this State.

"Medicare supplement policy" or "medicare supplement insurance policy" means a group or individual policy of disability insurance or any other subscriber contract which is advertised, marketed, or designed primarily to provide health care benefits as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare by reason of age. The term does not include:

(1) A policy or subscriber contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations; or

(2) A policy or subscriber contract of any professional, trade, or occupational association for its members, for former or retired members, or combination thereof, if the association:

(A) Is composed of individuals all of whom are actively engaged in the same profession, trade, or occupation;

(B) Has been maintained in good faith for purposes other than obtaining insurance; and

(C) Has been in existence for at least two years prior to the date of its initial offering of such policy or plan to its members; or

(3) Individual policies or subscriber contracts issued pursuant to a conversion privilege under a policy or subscriber contract of group or individual insurance when the group or individual policy or subscriber contract includes provisions which are inconsistent with the requirements of sections 431:10A-302 to 431:10A-309, HRS.

"Subscriber" means the individual whose status, except for family dependency, is the basis for eligibility for enrollment in a health maintenance organization. [Eff 5/22/89] (Auth: HRS §§431:2-201, 431:10A-304) (Imp: HRS §431:10A-301)

SUBCHAPTER 2

STANDARDS FOR POLICY PROVISIONS AND DISCLOSURE

§16-12A-10 Benefit conversion requirements. (a) No medicare supplement insurance policy, subscriber contract, or certificate in force in this State shall contain benefits which duplicate benefits provided by medicare.

(b) General requirements:

(1) No later than thirty days prior to the annual effective date of medicare benefit changes mandated by the Medicare Catastrophic Coverage Act of 1988, every insurer, health care service plan, or other entity providing medicare supplement insurance or benefits to a resident of this State shall notify its policy holders, contract holders, and certificate holders of modifications it has made to medicare supplement insurance policies or subscriber contracts. The notice shall be in a format prescribed by the commissioner and

in the format adopted by the National Association of Insurance Commissioners (NAIC) in June 1988, as shown in Exhibit A entitled "Notice of Changes in Medicare and Your Medicare Supplement Insurance-1989," dated November 1, 1988, located at the end of this chapter, and made a part of this chapter.

(A) The notice shall include a description of revisions to the medicare program and a description of each modification made to the coverage provided under the medicare supplement insurance policy or subscriber contract;

(B) The notice shall inform all covered policy holders, contract holders, and certificate holders as to when any premium adjustment due to changes in medicare benefits will be made; and

(C) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension. Such notice shall not contain or be accompanied by any solicitation;

(2) No modifications to an existing medicare supplement contract or policy shall be made at the time of or in connection with the notice requirements of this chapter except to the extent necessary to eliminate duplication of medicare benefits and any modifications necessary under the policy or subscriber contract to provide indexed benefit adjustment;

(3) As soon as practicable, but no later than forty-five days after the effective date of the medicare benefit changes, every insurer, health care service plan, or other entity providing medicare supplement insurance or subscriber contracts in this State shall file with the division in accordance with the applicable filing procedures of this State:

(A) Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or subscriber contracts. Such supporting documents as necessary to justify the adjustment shall accompany the filing; and

(B) Any appropriate riders, endorsements, or policy forms needed to accomplish the medicare supplement insurance modifications necessary to eliminate benefit duplications with medicare. Any such riders, endorsements, or policy forms shall provide a clear description of the medicare supplement benefits provided by the policy or subscriber contract;

(4) Upon satisfying the filing requirements of this State, every insurer, health care service plan, or other entity providing medicare

supplement insurance in this State shall provide each covered person with any rider, endorsement, or policy form necessary to eliminate any benefit duplications under the policy or subscriber contract with benefits provided by medicare;

(5) No insurer, health care service plan, or other entity shall require any person covered under a medicare supplement policy or subscriber contract which was in force prior to the effective date of this chapter to purchase additional coverage under such policy or subscriber contract unless such additional coverage was provided for in the policy or subscriber contract; and

(6) Every insurer, health care service plan, or other entity providing medicare supplement insurance or benefits to a resident of this State shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or subscriber contract as will conform with minimum loss ratio standards for medicare supplement policies and which is expected to result in a loss ratio at least as great as that originally anticipated by the insurer, health care service plan, or other entity for such medicare supplement insurance policies or subscriber contracts. No experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date. Premium adjustments shall be in the form of refunds or premium credits and shall be made no later than upon renewal if a credit is given, or within sixty days of the renewal date if a refund is provided to the premium payer. [Eff 5/22/89] (Auth: HRS §§431:2-201, 431:10A-303) (Imp: HRS §§431:10A-304, 431:10A-307)

§16-12A-11 Requirements for new policies and certificates. (a) No medicare supplement insurance policy, subscriber contract, or certificate shall be issued or issued for delivery in this State which provides benefits which duplicate benefits provided by medicare. No such policy, subscriber contract, or certificate shall provide less benefits than those required under the existing Medicare Supplement Minimum Standards Act or Regulations except where duplication of medicare benefits would result.

(b) General requirements:

(1) Within ninety days of the effective date of this chapter, every insurer, health care service plan, or other entity required to file its policies or subscriber contracts with this State shall file new medicare supplement insurance policies or subscriber contracts which eliminate any duplication of medicare supplement benefits

with benefits provided by medicare and which provides a clear description of the policy or subscriber contract benefit;

(2) The filing required under paragraph (1) shall provide for loss ratios which are in compliance with all minimum standards; and

(3) Every applicant for a medicare supplement insurance policy subscriber contract or certificate shall be provided with an outline of coverage as described in section 16-12-9 which simplifies and accurately describes benefits provided by medicare and policy or subscriber contract benefits along with benefit limitations. [Eff 5/22/89] (Auth: HRS §§431:2-201, 431:10A-303) (Imp: HRS §431:10A-304)

§16-12A-12 Filing requirements for advertising. Every insurer, health care service plan, or other entity providing medicare supplement insurance or benefits in this State shall provide upon reasonable request a copy of any advertisement intended for use in this State whether through written, radio, or television medium to the commissioner for review. Such advertisement shall comply with all applicable laws of this State. [Eff 5/22/89] (Auth: HRS §§431:2-201, 431:10A-303, 431:13-203) (Imp: HRS §431:13-103)

§16-12A-13 Buyer's guide. No insurer, health care service plan, or other entity shall make use of or otherwise disseminate any buyer's guide or informational brochure which does not accurately outline current medicare benefits and which has not been approved by the commissioner. [Eff 5/22/89] (Auth: HRS §§431:2-201, 431:10A-303) (Imp: HRS §431:10A-307)

§16-12A-14 Automatic changes. All medicare supplement policies, contracts, and certificates shall provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amounts and co- payment percentage factors set by law. Premiums may be modified to correspond with such changes. [Eff 5/22/89] (Auth: HRS §§431:2-201, 431:10A-303) (Imp: HRS §431:10A-304)

§16-12A-15 Standards of claims payment. Every entity providing medicare supplement policies or subscribers contracts shall comply with all provisions of section 4081 of the Omnibus Budget Reconciliation Act of 1987 and the Medicare Catastrophic Coverage Act of 1988. [Eff 5/22/89] (Auth: HRS §§431:2-201, 431:10A-303) (Imp: HRS §431:10A-304)

§16-12A-16 Notice of participation. All entities providing medicare supplement policies, subscribers contracts, or certificates shall print on the first page of all policies, contracts, or certificates in nothing less than eighteen point type and in bold-faced print the following: "You must be a participant in both Part A and Part B of your medicare insurance in order to receive the full benefits of your medicare supplement policy or contract." [Eff 5/22/89] (Auth: HRS §§431:2-201, 431:10A-303) (Imp: HRS §431:10A-307)

§16-12A-17 Severability. If any provision of this chapter or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby. [Eff 5/22/89] (Auth: HRS §§431:2-201, 431:10A-303) (Imp: HRS §431:10A-301)

Chapter 16-12-A, Hawaii Administrative Rules, on the Summary Page dated March 30, 1989, was adopted on March 30, 1989, following a public hearing held on March 30, 1989, after public notices were given in the Honolulu Star-Bulletin and Honolulu Advertiser on March 4, 1989.

The adoption of Chapter 16-12A shall take effect ten days after filing with the Office of the Lieutenant Governor.

/s/ Robin K. Campaniano
ROBIN K. CAMPANIANO
Commissioner of Insurance

APPROVED AS TO FORM: Date: 5/2/89

/s/ Ann Catherine Blank
Deputy Attorney General

APPROVED: Date: 5/4/89

/s/ Robert A. Alm
ROBERT A. ALM
Director of Commerce and Consumer Affairs

APPROVED: Date: 5/12/89

John Waihee
JOHN WAIHEE
Governor of Hawaii

May 12, 1989
Filed

DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

Adoption of Chapter 16-12A
Hawaii Administrative Rules

March 30,1989

SUMMARY

Chapter 16-12A, Hawaii Administrative Rules, entitled "Medicare Supplement Policies," is adopted.